CALIFORNIA HEALTH ADVOCATES

Supplementing Medicare: Medigap Plans

Medigap Policies

Insurance Companies sell supplemental insurance to cover part, or all, of Medicare's co-payments and deductibles. These are known as Medigap policies. Some plans may include benefits for services that Medicare doesn't pay for, such as health care costs incurred while traveling outside the U.S. or excess charges when seeing a provider who does not accept Medicare assignment. A Medigap plan is guaranteed to be renewable and cannot be cancelled because of a person's health or for any other reason, unless the premium isn't paid. By law, companies can offer only 12 standardized Medigap benefit packages, labeled A through L. A high deductible rider can also be sold with Plans F and J. High deductible plans F and J with this optional rider will pay benefits exactly as regular Plans F and J, only after you meet the annual deductible f ($1,860 in 2007). Once the deductible is met, the plan pays its benefits for the rest of that year. The annual deductible amount increases each year. (See attached chart for details.)

A Medicare Select Medigap policy is a hybrid Medigap policy that supplements Medicare but also utilizes a network of providers. A Medicare SELECT Medigap policy will cover part or all of your Medicare co-payments and deductibles if you see providers that are within the plan's network. Some Medicare Select policies may also require you to pay a small co-payment when you visit a doctor, a feature that is not allowed in other standardized Medigap polices. If you use providers that are outside the network you will not receive the full benefits of the plan and the Medicare Select policy may pay less for your care.

Medigap plans are sold through licensed insurance agents, by sponsoring groups or through the mail. Retiree plans offered by former employers or Unions do not have to conform to these standardized requirements and are not called Medigap policies, even though they may work in much the same way as a Medigap policy.

Note: If you receive full Medi-Cal benefits you do not need a Medigap policy, and it is illegal for companies to sell you one. If you have one when you become eligible for Medi-Cal you have the option of keeping it to see providers that don't take Medi-Cal, or placing your policy on hold for up to twenty-four months. If you have Medi-Cal with a share of cost (SOC), you do have the option of buying a Medigap policy.

Health Screening

You may apply for a Medigap policy at any time, but companies selling Medigap plans can refuse to sell you a plan because of a past or current health condition. There are certain times however when, by law, companies must sell you a Medigap plan regardless of your health. These times are called "Open Enrollment" and "Guaranteed Issue" periods, and they occur when people are first eligible for Medicare or following specific events.

Note: Medicare beneficiaries younger than 65-years-of-age who have Medicare because of a disability, have the right to buy a Medigap policy during the first six months after signing up for Medicare Part B, unless they have End Stage Renal Disease (ESRD). Companies are allowed to charge a higher premium for people who are not yet 65 years old. For more information on open enrollment periods and Guaranteed Issue Rights, see our Fact Sheet "Supplementing Medicare: Your Right To Purchase a Medigap Policy" (www.cahealthadvocates.org).

Waiting Period

Some companies impose a waiting period before paying benefits for a pre-existing condition. This waiting period cannot last more than six months, and it applies only to those conditions that were treated during the six months prior to purchasing the policy.

Note: If you had health coverage during the six months prior to purchasing a Medigap plan, there will be no waiting period. If you are in a Guaranteed Issue period or you are buying a new Medigap policy to replace another Medigap plan, the company cannot impose any waiting period for your new policy.

Premiums

Even though Medigap policies are standardized, premiums can vary from company to company. Most companies base premiums on an individual's age. Most base a premium on your zip code. Some charge smokers extra and others offer a variety of discounts. Very few companies charge everyone the same price, regardless of their age or marital status. Many companies charge a higher premium for a person with a disability who is younger than 65-years old, than they do for someone 65-years-old and over with the same policy. Most companies increase the amount of their premiums each year. It is important to compare policies and premiums from different companies before making a decision to buy. You can find information about companies selling Medigap plans in California and some sample premiums at the California Department of Insurance website: www.insurance.ca.gov.

Basic Benefits In All A - J Plans

Medigap plans A – J must offer the following basic benefits:

- Co-insurance for hospital days 61-90 ($248/day in 2007) and co-insurance for the 60 lifetime reserve days ($496/day in 2007).
- 100% of the cost of hospital care beyond 150 days covered by Medicare, up to a maximum of 365 lifetime days.
- 20% co-insurance for Medicare approved charges after the $131 annual Part B Medicare deductible has been met.
- The first three pints of blood in each calendar year.

*These basic benefits are the **only** benefits in Plan A on the chart below.*

Standardized Medigap Plans

	A	B	C	D	E	F*	G	H	I	J*
Basic Benefits: All Part A hospital co-insurance plus 100% of costs for a lifetime maximum of 365 additional hospital days; Part B co-insurance (20% of the Medicare-approved amount); three pints of blood in a calendar year	X	X	X	X	X	X	X	X	X	X
Part A Hospital Deductible: First day deductible, $992 in 2007 (per benefit period)		X	X	X	X	X	X	X	X	X
Skilled Nursing Facility (SNF) Co-payment: $124 per day for days 21-100 of *Medicare covered stay* in a skilled nursing facility (per benefit period)**			X	X	X	X	X	X	X	X
Part B Deductible: First $131 of Part B services each year			X			X				X
Part B Excess Charges: 80% or 100% of physician charges up to 15% above the Medicare-approved amount						100%	80%		100%	100%

Foreign Travel Emergency Care: 80% of emergency care during the first two months of each trip outside the USA after a $250 deductible, for a lifetime maximum of $50,000			X	X	X	X	X	X	X	X
At-Home Recovery Maximum of $40/visit up to $1600 a year, while receiving Medicare-covered home health care, or up to 8 weeks of home care after Medicare covered home care ends				X			X		X	X
Preventive Care: $120 per year for preventive care not covered by Medicare					X					X

*Plans F and J may be sold with a high deductible option of $1860 in 2007. The benefits remain the same, but the deductible must be met each year before any claims will be paid.

** "Benefit Period" begins the day you go to a hospital or a SNF and ends with the close of a period of 60 consecutive days during which the individual was neither an inpatient of a hospital nor an inpatient of a SNF.

NOTE: Plans H, I and J are no longer available with drug coverage. The plans still exist, but new enrollees into these plans will not receive drug coverage with these plans. You can only renew Medigap Plans H, I and J purchased before to December 31, 2005 under one of two conditions:

A. Medigap plans H, I, or J can only be renewed if the prescription drug benefits are removed, or
B. You can only keep Medigap plans H, I, or J with prescription drug benefits until you enroll in any plan with Medicare Part D benefits.

Medicare Supplemental Insurance Standardized Plans

Plans K and L

	K	L
Basic Benefits All Part A hospital co-insurance, plus 100% of costs for a lifetime maximum of 365 additional hospital days; and 100% of Part B coinsurance for Preventive Services after the Part B deductible has been met.	50% of Part A deductible 50% of Hospice cost-share 50% of the first three pints of blood 50% of Part B co-insurance	75% of Part A deductible 75% of Hospice cost-share 75% of the first three pints of blood 75% of Part B co-insurance
Part A deductible	-0-	-0-
SNF Co-Insurance	50%	75%
Part B **Annual deductible***** **Excess charges**	 -0- -0-	 -0- -0-
Total Out of Pocket Limit	$(4,000) Out of Pocket Annual Limit****	$(2,000) Out of Pocket Annual Limit*****

*** The payment by the insured person of this deductible amount is credited towards the Annual Out of Pocket Limit of each plan.

**** After $4,000 in out of pocket expenses for covered benefits has been paid during a calendar year by the person covered by Plan K, the plan then pays 100% of any remaining covered benefits for the remainder of that calendar year. The Part B deductible ($131 in 2007) is not a covered benefit but it does count towards the $4,000 out of pocket limit. Payment of the Part A deductible also counts towards the out of pocket limit, but the payment of excess charges does not.

*****After $2,000 in out of pocket expenses for covered benefits has been paid during a calendar year by the person covered by Plan L, the plan then pays 100% of any remaining covered benefits for the remainder of that calendar year. The Part B deductible ($131 in 2007) is not a covered benefit but it does count towards the $2,000 out of pocket limit. Payment of the Part A deductible also counts towards the out of pocket limit, but the payment of excess charges does not.

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The Health Insurance Counseling and Advocacy Program (HICAP) provides free, objective information and counseling on Medicare and other related topics. You can call **1-800-434-0222** with your questions or to make an appointment at the HICAP office nearest you. To find the HICAP office in your area, visit http://www.calmedicare.org/counseling/.